April 21, 2003

Re: Medical Dispute Resolution
MDR #: M2-03-0599-01

In accordance with the requirement for TWCC to randomly assign cases to IROs, TWCC assigned your case to _____ for an independent review. _____ has performed an independent review of the medical records to determine medical necessity. In performing this review, _____ reviewed relevant medical records, any documents provided by the parties referenced above, and any documentation and written information submitted in support of the dispute.

The independent review was performed by a matched peer with the treating health care provider. Your case was reviewed by a physician who is Board Certified in Chiropractic Medicine.

Clinical History:
This male patient was injured on ___. He received thirteen stitches for his laceration and was treated for the effects of a closed-head injury. The patient reported increased symptoms such as memory loss, disorientation and tingling and numbness of the right side of his body approximately one week after his injury.

Diagnostic tests were performed, indicating cervical disc herniations at C-5 and C6-7. Surgical interventions were recommended, but no records of this procedure are included for review. The patient did receive chiropractic care during this time. He then pursued psychotherapy and individual pain management during the latter half of 2002. The outcome of those therapies indicates progress was consistent and had not plateaued.

Disputed Services:
Thirty-day multidisciplinary pain management program.

Decision:
The reviewer agrees with the determination of the insurance carrier. The reviewer is of the opinion that the requested pain management program is not medically necessary in this case.

Rationale for Decision:
The clinical information provided does not support the medical necessity of this program. The patient continues to respond to the individual psychotherapy and biofeedback treatments. Since this conservative care has proven to show measurable progress, there is no further need at this time for additional care.

I am the Secretary and General Counsel of___ and I certify that the reviewing physician in this case has certified to our organization that there are no known conflicts of interest that exist between him and any of the treating physicians or other health care providers or any of the physicians or other health care providers who reviewed this care for determination prior to referral to the Independent Review Organization.

We are simultaneously forwarding copies of this report to the payor and the Texas Workers' Compensation Commission. This decision by ____ is deemed to be a Commission decision and order.

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of this decision and has a right to request a hearing.

If disputing a spinal surgery prospective decision a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings **within ten (10) days** of your receipt of this decision (28 Tex. Admin. Code 142.5©).

If disputing other prospective medical necessity (preauthorization) decisions a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings **within twenty (20) days** of your receipt of this decision (28 Tex. Admin. Code 148.3).

This Decision is deemed received by you **five (5) days** after it was mailed (28 Tex. Admin. Code 102.4(h) or 102.5 (d)). A request for a hearing should be sent to:

Chief Clerk of Proceedings
Texas Workers' Compensation Commission
P.O. Box 40669
Austin, TX 78704-0012

A copy of this decision should be attached to the request. The party appealing the decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute.

I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to the carrier, the requestor and claimant via facsimile or U.S. Postal Service from the office of the IRO on April 21, 2003

Sincerely,